

# CLINICAL AIDS

Disease	Diagnosis Date (mm/dd/yyyy)	dx method <sup>5</sup>	
		Presumptive	Definitive
Candidiasis, bronchi, trachea, or lungs	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Candidiasis, esophageal	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Cervical cancer, invasive	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Coccidioidomycosis, disseminated or extrapulmonary	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Cryptococcosis, extrapulmonary	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Cryptosporidiosis, chronic <sup>6</sup> intestinal	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Cytomegalovirus disease (other than liver, spleen, or nodes)	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Cytomegalovirus retinitis (with loss of vision)	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
HIV encephalopathy	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Herpes simplex: chronic <sup>6</sup> ulcers; or bronchitis, pneumonitis, or esophagitis	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Histoplasmosis, diss. or extrapulmonary	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Isosporiasis, chronic <sup>6</sup> intestinal	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Kaposi's sarcoma	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Lymphoma, Burkitt's (or equivalent)	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Lymphoma, immunoblastic (or equivalent)	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Lymphoma, primary in brain	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Mycobacterium avium complex or M. kansasii, diss. or extrapulmonary	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
M. tuberculosis, pulmonary	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
M. tuberculosis, diss. or extrapulmonary	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Mycobacterium of other or unidentified species, diss. or extrapulmonary	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Pneumocystis pneumonia	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia, recurrent <sup>7</sup>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Progressive multifocal leukoencephalopathy	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Salmonella septicemia, recurrent	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Toxoplasmosis of brain	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Wasting syndrome due to HIV <sup>8</sup>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>

**Return completed form to:**



**Clark County Public Health**  
**P.O. Box 9825**  
**Vancouver, WA 98666-8825**  
**Attn: Jan Schmalenberger**  
**(360) 397-8000, ext. 7208**

## FOOTNOTES

- <sup>1</sup>Patient identifier information is not sent to CDC.
- <sup>2</sup>Outpatient dx: ambulatory diagnosis in a physician's office, clinic, group practice, etc.  
 Inpatient dx: diagnosed during a hospital admission of at least one night.
- <sup>3</sup>After 1977 and preceding the first positive HIV antibody test or AIDS diagnosis.
- <sup>4</sup>If case progresses to AIDS, please notify health department.
- <sup>5</sup>If further clarification of definitive and presumptive diagnostic methods is needed, please contact health department.
- <sup>6</sup>Chronic: more than one month's duration.
- <sup>7</sup>Recurrent: 2 or more episodes within a 1-year period.
- <sup>8</sup>Wasting syndrome due to HIV infection includes >10% weight loss plus 1) chronic diarrhea and/or 2) fever and chronic weakness lasting over 30 days in absence of a concurrent illness other than HIV which could explain the findings (e.g., cancer, TB, cryptosporidiosis, or other specific enteritis).

## FOR HEALTH DEPARTMENT USE ONLY

ID Code		
FUI Assigned:		
<input type="checkbox"/> Complete	<input type="checkbox"/> Incomplete	<input type="checkbox"/> OOS
RVCT Number:		

## WASHINGTON STATE REPORTING REQUIREMENTS

AIDS and HIV infection are reportable to local health authorities in Washington in accordance with WAC 246-101. HIV/AIDS cases are reportable within 3 working days and reporting does not require patient consent.

## ASSURANCES OF CONFIDENTIALITY AND EXCHANGE OF MEDICAL INFORMATION

- Several Washington State laws pertain to HIV/AIDS reporting requirements. These include: Maintain individual case reports for AIDS and HIV as confidential records (WAC 246-101-120,520,635); protect patient identifying information, meet published standards for security and confidentiality if retaining names of those with asymptomatic HIV, (WAC 246-101-230,520,635); investigate potential breaches of confidentiality of HIV/AIDS identifying information (WAC 246-101-520) and not disclose HIV/AIDS identifying information (WAC 246-101-120,230,520,635 and RCW 70.24.105).
- Health care providers and employees of a health care facilities or medical laboratories may exchange HIV/AIDS information in order to provide health care services to the patient and release identifying information to public health staff responsible for protecting the public through control of disease (WAC-246-101-120, 230 and 515; and RCW 70.24.105).
- Anyone who violates Washington State confidentiality laws may be fined a maximum of \$10,000 or actual damages; whichever is greater (RCW 70.24.080-084).

## FOR PARTNER NOTIFICATION INFORMATION

- Washington state law requires local health officers and health care providers to provide partner notification assistance to persons with HIV infection (WAC 246-100-209) and establishes rules for providing such assistance (WAC 246-100-072).
- For assistance in notifying spouses, sex partners or needle-sharing partners of persons with HIV/AIDS, please call HIV/AIDS Prevention & Education Services, DOH, at (360) 236-3422, or your local health department. In King County, please call Edith Allen, Public Health Seattle & King County, at (206) 731-4377.

Comments:

Patient Name <sup>1</sup> (Last, First, Middle):		
AKA (Nickname, Previous Last Names, etc.)		
Phone #: ( ) -	Social Security #: - -	
Current Street Address:		
City:	Zip Code:	[1] Alive [2] Dead
Birthdate (mm/dd/yyyy) / /	Death Date (mm/dd/yyyy) / /	State of Death:
Sex at birth: [1] Male [2] Female	Gender or identity change: [1] Male to Female [2] Female to Male	Ethnicity: [1] Hispanic [2] Not Hispanic
Race (check all that apply): <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> American Indian/Alaska Native		Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Never married <input type="checkbox"/> Unknown
Country of birth: <input type="checkbox"/> U.S. <input type="checkbox"/> Other: _____ If other, length of residence in US: _____		
Was patient dx in another state? [1] Yes [2] No If yes, specify state: _____		
Residence at time of diagnosis if different than current address: City: _____ County: _____ Zip Code: _____		
Med. Record #/Patient Code:		
Name & City of facility of diagnosis:		
[1] Outpatient dx <sup>2</sup> [2] Inpatient dx <sup>2</sup>		

PROVIDER INFORMATION		
Physician:	Phone:	City:

Person reporting if other than physician:	Phone:
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PATIENT HISTORY SINCE 1977 <sup>3</sup>			
Check all that apply	Yes	No	Unk
Sex with male.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sex with female.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Injection drug use.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Received clotting factors for hemophilia.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transfusion, Transplant, or Insemination.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heterosexual relations with:			
Injection drug user.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bisexual man.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Person with hemophilia.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PWA/HIV transfusion or transplant....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PWA/HIV risk not specified.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Worked in health-care or laboratory setting..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, occupation: _____			

CONFIDENTIAL HIV/AIDS ADULT CASE REPORT			
LABORATORY DATA <sup>4</sup>			
Test Date (mm/dd/yyyy)			
Last documented negative test ____/____/____ Type of test: _____			
EARLIEST POSITIVE HIV ANTIBODY TESTS:			
Type of Test:	Test Date (mm/dd/yyyy)		
HIV-1 EIA	____/____/____		<input type="checkbox"/> Test not done
HIV-1 Western Blot or IFA	____/____/____		<input type="checkbox"/> Test not done
HIV VIRAL LOAD TESTS:			
Type of Test:	Test Date (mm/dd/yyyy)		
Earliest HIV Viral Load	____/____/____		<input type="checkbox"/> Copies per mL <input type="checkbox"/> Undetectable
Most recent HIV Viral Load	____/____/____		<input type="checkbox"/> Copies per mL <input type="checkbox"/> Undetectable
OTHER HIV TESTS			
Type of test: Rapid, Antigen, Culture, HIV-2, _____			
Date (mm/dd/yyyy): ____/____/____		Result: _____	
PHYSICIAN DIAGNOSIS OF INFECTION:			
No laboratory tests are available but Physician documents HIV infection Date (mm/dd/yyyy): ____/____/____			
EARLIEST DRUG RESISTANCE TEST			
Date (mm/dd/yyyy): ____/____/____		<input type="checkbox"/> Test not done	
Type: Genotype	Phenotype		
Laboratory: _____			
CD4 LEVELS			
Type of Test:	Test Date (mm/dd/yyyy)	Count	Percent
Earliest CD4	____/____/____	_____ cells/μl	_____ %
Most Recent CD4	____/____/____	_____ cells/μl	_____ %
First CD4 <200 μl or < 14%	____/____/____	_____ cells/μl	_____ %

TREATMENT / SERVICES REFERRALS				
	Yes	No	Unk	NA
Has this patient been informed of his/her HIV infection?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
This patient is receiving/has been referred for:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
• HIV related medical service				
• HIV Social Service Case Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
• Substance abuse treatment services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
This patient received/ is receiving:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
• Antiretroviral (ARV) therapy				
If yes, earliest date started ARV after diagnosis (mm/dd/yyyy): ____/____/____				
• PCP prophylaxis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
FOR WOMEN				
Is this patient currently pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Yes	No	Unk	
Expected delivery date (mm/dd/yyyy) ____/____/____				

HEALTH DEPARTMENT USE ONLY		
<input type="checkbox"/> HIV	<input type="checkbox"/> AIDS	Stateno: _____
Date: ____/____/____	Source: _____	
<input type="checkbox"/> New Case	<input type="checkbox"/> Progression	<input type="checkbox"/> Update, no status change

Note AIDS indicator diseases on reverse
<input type="checkbox"/> CHECK HERE IF PATIENT HAS NO AIDS INDICATOR DISEASES If checked, skip Clinical AIDS section on reverse.

HIV TESTING HISTORY	
Complete this section if new diagnosis or new patient	
OR attach completed questionnaire	<input type="checkbox"/> Not applicable

Date of information collected (mm/dd/yyyy): ____/____/____
Information from: <input type="checkbox"/> patient interview <input type="checkbox"/> review of medical record

FIRST SELF-REPORTED POSITIVE HIV TEST
Date (mm/yyyy): ____/____/____ State: _____
Registration type: <input type="checkbox"/> Confidential <input type="checkbox"/> Anonymous <input type="checkbox"/> Unk/Refused

LAST SELF-REPORTED NEGATIVE HIV TEST
<input type="checkbox"/> Never had negative HIV test <input type="checkbox"/> Unk (Skip to next section)
Date (mm/yyyy): ____/____/____

OTHER HIV TESTS
Number of HIV tests in 2 years before first positive (include first positive result):
$\frac{1}{\text{first positive test}} + \frac{\text{\# of negative tests during prior 2 years}}{\text{total \# of tests in 2 years}} =$

ANTIRETROVIRAL (ARV) USE BEFORE DIAGNOSIS OF HIV			
	Yes	No	Unk
Used ARV in 6 months before diagnosis:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes: Names of medications used: _____ Continue in comments on reverse if necessary			
First date of ARV use (mm/dd/yyyy): ____/____/____			
	Yes	No	Unk
Currently using ARV:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If no: Last date of ARV use (mm/dd/yyyy): ____/____/____			

DRUG USE			
Methamphetamine use?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk
If, yes: <input type="checkbox"/> Injection <input type="checkbox"/> Non-injection, specify: _____ <input type="checkbox"/> Unk			

PARTNER NOTIFICATION (PN)
For <b>previously unreported HIV/AIDS cases</b> , WAC 246-100-072 indicates that the local health officer or designee is required to contact the health care provider within 7 days to offer partner notification assistance.
Health care provider has been contacted to offer PN assistance. <input type="checkbox"/> Yes <input type="checkbox"/> No
If no, reason not contacted: _____
<b>Disposition:</b>
<input type="checkbox"/> Health care provider accepts assistance from LHJ in conducting PN.
<input type="checkbox"/> Health care provider assumes responsibility for working with patient to conduct PN activities.